Providing Family PACT Services During COVID-19: Understanding Benefit Changes
September 17, 2020
Questions & Answer Document

Telehealth

1. **Our center does not have any policies in place for which visits should be remote. Do you have a policy to use for reference?**

   Yes. The Family Planning National Training Center has an excellent job aid for your practice that explains how to triage appointment requests to phone call, telemedicine visit, or in-person visit. It can be found at:

   https://www.fpntc.org/resources/prioritization-person-and-virtual-visits-during-covid-19-decision-making-guide-staff

2. **How would a clinician code a visit for one of your examples if the clinician is seeing the client from home by telephone only?**

   A telephonic-only visit would be billed based on the *time* that the clinician was on the phone with the client, using one of the Evaluation and Management (E/M) codes covered by Family PACT. The claim must include a -95 modifier (telehealth visit) attached to the E/M code. The "place of service" code is entered as -02.

   Note that there are very specific Medi-Cal and Family PACT policies regarding when a telephonic-only visit can be billed in lieu of an office visit. These were detailed during the webinar and the criteria are listed in the slide set, which you can download.

   https://familypact.org/wp-content/uploads/2020/09/9.17.20-Family-PACT-Update-Policar-final-final-on-9.17.20_improved-color-contrast_remEQ.pdf

   Below is the link to the Medi-Cal Provider letter that contains these policies:

   https://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications-6-19.pdf

3. **Can E/M codes can be billed if only telephone used and not A/V or since it was only telephone should G2012 be billed?**

   This policy was described in detail in the presentation (slides 13-19) and in Question #2 above. To summarize: an E/M code can be used to bill for a telephonic visit during the public health emergency (based on the time) as long as certain criteria are met. If all of the criteria are not met, then bill G2012.

4. **How would we bill for this type of hybrid care: a telehealth visit for STI testing (over the phone only) then having the client come in for labs only?**

   The (telephonic) telemedicine visit should be billed with an E/M code based on the time interval of the conversation between the clinician and the client, assuming that the criteria for a telephonic visit are met (see Question #2). When the client is seen subsequently in the clinic for lab tests only, an E/M code should NOT be billed,

since the client did not need another visit with a clinician. Medically indicated point-of -care tests (e.g., pregnancy test, wet mount) that are Family PACT benefits can be billed, while the lab will bill for tests that are sent out, such as a gonorrhea and chlamydia NAAT.

5. **If I understand regarding the billing, the visits that are billed based on time only are billed less than a telephone visit where and E/M and modifier code is used.**

   An E/M visit is billed either on the basis of 3 key components or time (see Question 12, below, for time frames). Telehealth visits (audio/video) and telephonic-only visits (during public health emergency) are paid at listed reimbursement rates. If a telephone interaction with a client does not meet the criteria for a telehealth visit, use G2012 (virtual check-in visit). This code does pay less than most E/M codes.

6. **What does it need to include to bill FPACT for an e-consult visit?**

   An e-consult visit is billed by the consultant who renders an opinion about the care of a Family PACT client. The *request* for consultation must come from a Family PACT provider and the consultant must be enrolled as a Family PACT provider, as well.

   The request for consultation can be made by telephone, internet, or electronic health record. The E/M service must be provided by a consultative physician or qualified health provider (e.g., NP, PA, or CNM), including a written report to the requesting physician/QHP and the consultant's opinion must be entered into the client's medical record.

   The consultative physician/QHP who renders the written opinion can bill Family PACT using E/M code 99451. The requesting clinician cannot bill for simply making the request.

7. **Does telehealth have to be written into your existing grant or is it part of the pandemic response for emergent use?**

   There are no "grants" in Family PACT. It is a fee-for-service program.

8. **Can you share any best practices for working with immigrants who have privacy concerns about using telehealth technologies? I have heard that some immigrant clients do not want to use zoom and other platforms due to distrust and fears of surveillance by immigration enforcement.**

   I assume that studies have been done on this topic, but there are none in the family planning literature. There is an excellent CDC webinar on "Telehealth & Health Equity: Considerations for Addressing Health Disparities during the COVID-19 Pandemic" which may, in part, address your question. The link to the webinar is: https://emergency.cdc.gov/coca/calls/2020/callinfo_091520.asp.

9. Not sure if it applies to all of clinics or providers, but it is our understanding at our clinic, women annual exams are non-emergent, therefore, when will we be able to schedule without hesitation as far as when it is okay to book annual exams?

That is a decision that is up to your clinic or practice, depending any public health regulations in your community or county about re-opening of health care facilities.

Note that a large majority of well woman visits can be conducted as telemedicine visits, since most of the visit consists of counseling, anticipatory guidance and discussion of her pregnancy intentions and family planning needs. If a client is due for cervical cancer screening (which for most females will be every 3 or every 5 years), the well woman visit can be done as a telemedicine visit and she can delay her cytology or HPV test (or both) until the public health emergency has passed.

Also note that well women visits are no longer referred to as "annual visits". Many national guidelines (such as the US Preventive Services Task Force) and Family PACT standards state that Well Woman visit should be at least every two years, depending on the health status and risk behaviors of the client.

10. How detailed does the documentation need to be to support the level of visit?

The time spent on the visit between the clinician and the client must be documented, whether this is an audio/video telemedicine visit or a telephonic-only visit that meets the requirements described in Question 2.

11. Is a checklist of ranges of time spent sufficient to document time spent?

No. It's fine for you to integrate this into your electronic medical record template but circling a code or time interval is insufficient. In your medical record, you must document the specific number of minutes of face-to-face time and then choose an E/M code based on whether this is a new or established patient and where that number falls in the stated intervals. Remember that you also must document that at least 50% of the visit was spent in counseling.

New	Time	Established	Time
99201	≤ 15 min	99211	≤ 7 min
99202	16-25 min	99212	8-12 min
99203	26-37 min	99213	13-20 min
99204	38-53 min	99214	21-33 min

12. Does consent need to be obtained at each telehealth visit?

CA Executive Order N-43-20 signed by Governor Newsom on 4.3.20 suspends the telemedicine consent requirement during the public health emergency. It is likely that this will be rescinded (sunset) at some point, but a date has not been announced. Despite this Executive Order, many clinics have continued to obtain and document client consent for a telemedicine visit.

13. Do you foresee if telehealth visit as it is to be a continued option indefinitely after pandemic resolves?

Telehealth visits by audio/video communications were covered by Family PACT and Medi-Cal even before the public health emergency and will to continue to be a benefit after the PHE is over, as there are a variety of state regulations that require it in Medi-Cal. Telephonic-only visits were added as a benefit on June 23, 2020, owing to the recognition that many clients do not have access to computers, smart phones, high speed internet, or unlimited data-plans. How long this benefit will continue during the PHE and afterward has not been announced.

Birth Control

14. Are BP checks required for OCP and DMPA refills?

No, there is no BP measurement requirement by either Family PACT or Medi-Cal. However, CDC guidelines recommend that BP be checked periodically in women using OCs, patch or contraceptive vaginal ring. This recommendation is not made for DMPA, as it is a progestin-only method.

15. How many years maximum can you give depo? If a client has stopped and continued depo use, is the use of depo cumulative? Is there a maximum number of years that a client can be on depo?

According to the CDC Selected Practice Recommendations, there is no maximum number of years for DMPA use.

16. If clients opt to doing self-injection of depo-shot, are they supposed to do pregnancy test prior to injecting depo-shot?

Not routinely. If the interval between injections is 15 weeks or less and there are no reasons to suspect that the client may be pregnant, a pregnancy test is not necessary.

17. Since we are not yet open at all for in person visits, can I write a Rx for Depo SQ and can the client pick it up at pharmacy for self-injection? Do I need to approve needle or is it on depo already?

Yes, if a clinician has a discussion with the client and the decision is to prescribe DMPA-SQ for self-administration, a prescription must be transmitted to a Medi-Cal contracted pharmacy that stocks it. DMPA-SQ is dispensed as a pre-loaded syringe and needle for subcutaneous injection.

18. Is Plan B reimbursable at a clinic site or only when dispensed by a pharmacy?

Both. However, a prescription is necessary for the pharmacy to be paid for dispensing Plan B to a Family PACT client.

19. If we see the client for counseling for BCM and then they come back a few days later for LARC, will we be reimbursed for both visits? What is the correct way to bill for this scenario?

Yes. The first visit is billed using an E/M code based on the time of the visit with the clinician. The ICD-10 code for this visit will be Z30.09 (Encounter for other general counseling and advice on contraception). When the client returns for her LARC placement, use the CPT code for insertion of an IUD (58300) or insertion of a contraceptive implant (11981). In this case, do not bill an E/M code on the day of the LARC placement. The corresponding ICD-10 codes are Z30.430 for the placement of an IUD and Z30.017 (Encounter for initial prescription of implantable subdermal contraceptive) for an implant. Do not forget to bill the HCPCS code for the insertion kit.

Colposcopy & STIs

20. **If you do a pap on a client and the pap comes back HGSIL. Can we bring the client in for a colpo? If we do the colpo and it shows HGSIL, can we do a LEEP? If these services are not covered, how do we proceed?**

    All of the services are covered by Family PACT. Refer to the Family PACT PPBI, Section ben fam rel, pages 25-31 (Management of cervical abnormalities and preinvasive cervical lesions) for detailed advice about covered benefits. Please consult the 2019 ASCCP Guidelines for clinical management guidance.

21. **Do you know if other providers are delaying colpos at this time or delaying them due to PHE?**

    Yes. Many providers are following the guidance of the ASCCP regarding service time frames during the public health emergency. It can be found at: https://www.asccp.org//covid-19-resources.

22. **Do you understand why chlamydia is no longer on the list of reportable diseases for CA?**

    For additional information, please contact the California Department of Public Health.